Benefit integrity review means medical review of claim information and medical documentation focusing on addressing situations of potential fraud, waste and abuse.

Complex medical review means all medical review of claim information and medical documentation by a licensed medical professional, for a billed item or service identified by data analysis techniques or probe review to have a likelihood of sustained or high level of payment error.

Contractor, as used in this subpart, means intermediaries, carriers, Medicare Administrative Contractors (MACs), and program safeguard contractors (PSCs).

Error rate means the dollar amount of allowable charges for a particular item or service billed in error as determined by complex medical review, divided by the dollar amount of allowable charges for that medically reviewed item or service.

Initial error rate means the calculation of an error rate based on the results of a probe review prior to the initiation of complex medical review.

Medical review means the process performed by a contractor to ensure that billed items or services are covered and are reasonable and necessary as specified under section 1862(a)(1)(A) of the Act.

Nonclinician medical review staff means specially trained medical review staff not possessing the knowledge, skills, training, or medical expertise of a licensed health care professional.

Non-random prepayment complex medical review means the prepayment medical review of claim information and medical documentation, by a licensed medical professional, for a billed item or service identified by data analysis techniques or probe review to have a likelihood of sustained or high level of payment error.

Non-random prepayment medical review means the prepayment medical review of claims, by nonclinical or clinical medical review staff, for a billed item or service identified by data analysis techniques or probe review to have a likelihood of a sustained or high level of payment error.

Postpayment medical review means medical review of claims, by nonclinical or clinical medical review staff, for a billed item or service after a claim has been paid.

Provider-specific probe review means the complex medical review of a small sample of claims, generally 20 to 40 claims, from a specific provider or supplier for a specific billing code to confirm that or determine whether the provider or supplier is billing the program in error.

Random prepayment medical review means the prepayment medical review of claims, by nonclinical or clinical medical review staff, for a billed item or service that has not been identified by data analysis techniques or probe review to have a likelihood of a sustained or high level of payment error.

Quarterly error rate means the calculation of an error rate based on the results of non-random prepayment complex medical review for a specific billing code for a specific quarter.

Service-specific probe review means the complex medical review of a sample of claims, generally 100 claims, across the providers or suppliers that bill a particular item or service to confirm that or determine whether the item or service is billed in error.

Termination of non-random prepayment complex medical review means the cessation of non-random prepayment complex medical review.

§ 421.505 Termination and extension of non-random prepayment complex medical review.

(a) *Timeframe that a provider or supplier must be on non-random prepayment complex medical review.* There is no minimum timeframe that a provider or supplier must be on review. Except for cases described in paragraph (b) of this section, a contractor must terminate a provider or supplier from non-random prepayment complex medical review—

(1) No later than 1 year following the initiation of non-random prepayment complex medical review; or

(2) When calculation of the error rate indicates that the provider or supplier has reduced its initial error rate by 70 percent or more. A contractor must review claims for a specific billing code aberrancy for the quarter and calculate the quarterly error rate for those claims medically reviewed in that

quarter. In order for this determination to be made, the provider or supplier must submit a copy of the medical records that indicate that the items or services billed are covered, correctly coded, and are reasonable and necessary for the condition of the patient.

(3) When a provider or supplier is terminated from non-random prepayment complex medical review after 1 year of review and the contractor determines that the provider or supplier continues to have a high error rate despite educational interventions, the contractor must consider referring the provider or supplier to the contractor responsible for benefit integrity review. Contractors must also consider continuing educational interventions without performing further medical review or consider the need for post-payment medical review.

(b) *Extension of non-random prepayment complex medical review.* (1) A contractor has the discretion to extend non-random prepayment complex medical review if a provider or supplier stops billing the code under review, shifts billing to another inappropriate code to avoid proper calculation of the error rate, fails to respond to requests for medical records, or engages in any other improper claims or billing-related activity to avoid non-random prepayment complex medical review. If the reduction in the error rate is attributed to a 25 percent or greater reduction in the number of claims submitted for the specific billing code under review, non-random prepayment complex medical review for that provider or supplier may be extended. However, if the number of claims submitted for a specific code was reduced because the provider or supplier began billing claims using a new appropriate code, or there is another legitimate explanation for the reduced number of claims billed, the contractor retains discretion to terminate from or extend a provider or supplier on non-random prepayment complex medical review.

(2) If extended medical review is necessary, contractors must notify providers and suppliers in writing the reasons for the need to perform additional prepayment complex review.

(c) *Quarterly termination evaluation.* (1) Contractors, at a minimum, must evaluate the length of time a provider or supplier has been on non-random prepayment complex medical review on a quarterly basis.

(2) A determination as to whether the provider's or supplier's initial probe review error rate for a specific billing code has been reduced by 70 percent must also be evaluated quarterly. There is no minimum timeframe that a provider or supplier must be on review.

(3) The contractor's quarterly error rate evaluations must be for the discrete quarter; a rolling error rate average over more than 1 quarter is not permitted.

(4) After the contractor determines that the provider or supplier must be terminated from non-random prepayment complex medical review, the claims processing system must be updated within 5 business days to ensure that a provider's or supplier's claims for a specific billing error are no longer suspended for non-random prepayment complex medical review.

(d) *Periodic re-evaluation.* (1) Once a provider or supplier is terminated from non-random prepayment complex medical review, contractors may periodically re-evaluate the provider or supplier's data and may place a provider or supplier that appears to have resumed a high level of payment error on non-random prepayment complex medical review.

(2) This review would only be initiated if a probe review confirms that there continues to be a high level of payment error.

(3) If there is a high level of payment error, a provider or supplier may be placed on non-random prepayment complex medical review no earlier than 6 months after termination of a previous non-random prepayment complex medical review. As set forth in §421.505(a)(3) contractors may also refer the provider or supplier to the contractor responsible for benefit integrity review or place the provider or supplier on postpayment medical review.